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BOSTON UNIVERSITY

17 July 2014

Attorney-General Martha Coakley
Commonwealth of Massachusetts
18th floor
One Ashburton Place
Boston, MA 02108

Attention: Anti-Trust Division

Dear Attorney-General Coakley:

I'm concerned that the agreement you have recently negotiated with Partners concerning its combination with South Shore Hospital and other caregivers is not in the public interest. I'm writing this letter because Judge Sanders has ordered that comments on this agreement be submitted to you. Of course, I write individually and not on behalf of Boston University or any of its components.

First, since 1993, Partners has claimed that its various mergers and affiliations (which, for convenience, I'll call "combinations") sought to save money, and that they would save money or have saved money. But Partners has adduced no credible evidence to support those claims. Therefore, no one should believe Partners' assertions that still more combinations will save money.

Second, Partners has claimed that its combinations would improve quality of care. But it has provided neither credible evidence of past improvements in quality attributable to its combinations nor plausible arguments that its combinations are essential to future improvements in quality. See, for example, Thomas Tsai and Ashish Jha, "Hospital Consolidation, Competition, and Quality: Is Bigger Necessarily Better?" *JAMA*, Vol. 312, No. 1 (2 July 2014), pp. 29-30, http://jama.jamanetwork.com/article.aspx?articleid=1884584. See also Molly Gamble, "Integrated Chaos: Health Systems and the Aftermath of Defensive Physician Acquisitions," *Becker's Hospital Review.*, 9 June 2014, http://www.beckershospitalreview.com/hospital-physician-relationships/integrated-chaos-health-systems-and-the-aftermath-of-defensive-physician-acquisitions.html.

Third, Partners has generally argued that its various combinations would be good for the public. I contest this assertion and have long argued, with colleagues, that these combinations were designed mainly to benefit Partners by boosting the prices it is paid for care and thereby increasing its revenues, and thereby liberating it to spend and grow without fear of price competition. See Alan Sager, Deborah Socolar, and Peter Hiam, "Public Not Served by Merger of MGH, Brigham," *Boston Business Journal*, 14 January 1994, p. 13.

Fourth, over the past two decades, your predecessors, various Massachusetts governors, various commissioners of public health, and other high elected officials have chosen to believe—or said they believed—Partners' claims, assertions, and promises.

Fifth, the original Partners combination, with successive accretions, help to explain why the cost of Massachusetts hospital care specifically and Massachusetts health care generally has continued to rise. By reducing competition, Partners' combinations have helped to deepen the financial anarchy that allows health costs to rise. When anarchy prevails, the strong hospitals profit, and insurance premiums rise.

Financial anarchy results from the absence of anything close to a genuine competitive free market, or competent government regulation, or exercise of responsible fiduciary duty. It is no coincidence that the U.S. has both the world's most anarchic health care financing and the world's costliest hospital care and health care, and that Massachusetts has the nation's costliest health care generally—and the world's costliest hospital care specifically. Further, it is no accident that the Massachusetts excess over the U.S. average per-person health cost has continued to widen.

Sixth, you have negotiated and publicly trumpeted a set of apparent constraints on Partners' behavior. But you offer no convincing evidence that these constraints on behavior are likely to be practical, effective, or even enforceable. Have they been tried elsewhere? Did they work? How often? Without this evidence, it is likely that the constraints you have negotiated will actually enable Partners to garner substantial revenue increases. Right now, the constraints look like feeble regulatory Lilliputians, unable to restrain Partners' Gulliver.

Instead of providing evidence that the negotiated constraints on Partners' behavior are likely to work, you have focused on the procedural superiority of negotiating settlements over going to trial. You thereby trumpet form over substance—negotiating a deal with Partners instead of providing evidence that those constraints are likely to be enforceable and effective in restraining growth either in the prices paid to Partners' hospitals and doctors, or in the total revenue they garner. Please refer to your Memorandum of the Commonwealth of Massachusetts in Support of the Entry of Final Judgment, Commonwealth of Massachusetts v. Partners Healthcare System, Inc., South Short Health and Educational Corp., and Hallmark Health Corp., Suffolk Superior Court Civil Action No. 14-2033 B.L.S., filed 24 June 2014, p. 4.

Others do identify evidence that these constraints are not likely to work. See, for example, authorities cited in letter from Richard M. Brunell, General Counsel, American Antitrust Institute, to Hon. Christine Roach, Justice of the Superior Court, Suffolk Superior Court, 26 June 2014, concerning Commonwealth of Massachusetts v. Partners Healthcare System, Inc., South Short Health and Educational Corp., and Hallmark

Health Corp., Suffolk Superior Court Civil Action No. 14-2033 B.L.S., filed 24 June 2014. Please refer specifically to the third footnote.

In some respects, the constraints you have negotiated crudely parallel those of the state's putative effort to restrain health care costs, c. 224 of the Acts of 2012. But this is nothing to write home about. I don't know a single person who imagines that c. 224's approach will be effective. It might identify hospitals whose revenues grow faster than spending targets, but those hospitals will claim that various volume or case mix or technological changes justify that faster growth. Ceaseless finger-pointing will result. No one will be held accountable—especially if political pressure for health care cost control remains, like Nebraska's Platte River, a mile wide and an inch deep.

Seventh, despite the absence of evidence to support Partners' claims that its consolidations save money and improve quality, and despite the absence of evidence to support the enforceability and efficacy of your negotiated remedy that allows substantial new consolidations, you assert that your negotiated settlement will be financially and clinically beneficial to the people who need or pay for health care in the Commonwealth. Sadly, this assertion is not credible.

Eighth, therefore, we should look closely at alternatives. Four other paths forward are possible.

Path A is to introduce comprehensive state regulation of health care spending, including hospital budgets—as is being done in Maryland. See Rahul Rajkumar and others, "Maryland's All-payer Approach to Delivery-system Reform," *NEJM*, Vol. 370, No. 6 (6 Feb. 2014), pp. 493-5, http://www.nejm.org/doi/full/10.1056/NEJMp1314868.

Path B is to allow Partners to continue to grow—and even to encourage faster growth. The logical extension of this approach is to establish Partners as the sole provider and organizer of health care in the Commonwealth. It would receive all revenue and be accountable for delivering all effective and affordable services to all citizens. It would have to adhere to standards of universality, efficiency, and protection of the public interest in affordable, appropriate, high-quality care for all. It would have to deliver medical security to all residents—provision of needed care in a competent, kindly, and timely manner, within a budget, and without bankrupting recipients. This approach would oblige the New Partners to adopt a fiduciary and professional view of its role in delivering affordable and effective health care for all.

Path C is to wholeheartedly boost competition among hospitals and among doctors in hopes of lowering the prices paid for health care. Free market competition requires competitors, the more the better. Since Partners has produced no evidence that its combinations have bestowed benefits on the public—not lower prices and not better quality— and since market advocates believe that more competition is better, Partners

should be completely split into the individual, independent hospitals and physician groups that existed before 1 November 1993. So should all other multi-hospital systems or large groups of physicians. Strong advocates of free market competition in health care should support this position.

Path D is to sue Partners to break it up into two competing systems, one dominated by the General and the other by the Brigham. This will boost competition substantially. Payers will be able to play the two new systems off against one another. Substantially lower prices are likely to result.

These four approaches have various strengths and weaknesses. I think that path A is markedly superior to the agreement you have negotiated. But political support for this approach is unlikely to materialize until years have passed and until Massachusetts health care descends deeper into financial anarchy. Besides, it is outside your control.

Path B is intriguing. With court approval, the agreement you have negotiated with Partners will take our state's hospitals and doctors several big steps farther down this path. But it is unlikely that we all will reach the path's end any time soon. Impeding further progress are the fractious realities of Massachusetts hospital care and the belief that health care competition is a good idea.

Path C, demolishing Partners and all other hospital and doctor combinations in the past two decades is probably somewhat better than the agreement you have negotiated. It would take years or decades to accomplish. It would be expensive and acrimonious. And it would greatly heighten uncertainty facing Massachusetts health care at a time when other changes in health care access, payment methods, and organization of care already threaten to overwhelm management's capacity to cope.

Besides, health care does not come close to satisfying any of the six requirements for a functioning competitive free market. I don't think it can.

Current efforts to make available "transparent" prices and quality measures are not likely to provide clear information that most patients actually can or will use. Besides, knowing price and quality is not remotely sufficient: the most important question is whether recommended care is actually needed. We generally rely on doctors for that information. Advocating transparency, therefore, is largely a distraction. It tries to shoe-horn health care realities to fit some of the theoretical requirements of a market. Worse, the push for transparency helps to legitimate ever-higher out-of-pocket costs, which in reality constitute a regressive tax on sick people—especially those with illnesses that are costly to treat.

Path D is perhaps the most promising right now. It would constitute a relatively narrow intervention, one that is much less disruptive than any of the others. Its meanings

would be clear to the public. Although it would not generate anything close to a competitive free market, it would still boost price competition by slicing Partners' market power. Payers could play the General network against the Brigham network. Most insurers would want to offer members one network or the other, but few would need or want to include both. Prices would probably fall substantially from the high levels now actually paid to Partners' hospitals and doctors by insurers.

Attorney-General Coakley, I don't doubt for a second that you mean well. I believe that you hope to get the best deal from Partners that you can, given its great political influence. But I think the time has come to recognize that your negotiated agreement is not in the public interest, and to instead confront Partners in court by suing to divide it into two halves.

The resulting dramatic fight in court will offer an opportunity to educate the public about the high cost of financing business as usual in Massachusetts health care. And you might win! Partners might even settle. Especially if you write a strong Brandeis brief.

The complaint for injunctive relief that you recently filed (Commonwealth of Massachusetts v. Partners Healthcare System, Inc., South Short Health and Educational Corp., and Hallmark Health Corp., Suffolk Superior Court Civil Action No. 14-2033 B.L.S., filed 24 June 2014) outlines many of the types of arguments and evidence that you could include in such a brief. They would support a strong legal and educational campaign to divide Partners into two competing entities. .

I hope these thoughts are useful to you.—

Cordially,

Alan Sager, Ph.D.
Professor of Health Policy and Management
Director, Health Reform Program